NORTHERN IRELAND MEDICINES MANAGEMENT NEWSLETTER

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RISK OF HYPERKALAEMIA – TRIMETHOPRIM IN COMBINATION WITH SPIRONOLACTONE [9,10]

Hyperkalaemia is an important consideration in patients receiving spironolactone in clinical practice. Research has shown that it can occur in up to a third of patients receiving the drug, emphasising the need for regular electrolyte monitoring and the avoidance of other drugs than can cause hyperkalaemia.

Trimethoprim can reduce urinary potassium excretion by approximately 40%.

Elderly patients with chronic renal failure who are already taking spironolactone for heart failure are at an increased risk of admission to hospital for acute on chronic renal failure with hyperkalaemia when trimethoprim is prescribed for a UTI. The likelihood of co-prescription of trimethoprim and spironolactone is high.

A study in the British Medical Journal (BMJ) sought to characterise the risk of admission to hospital for hyperkalaemia in elderly patients treated with co-trimoxazole (trimethoprim plus sulfamethoxazole) in combination with spironolactone. The Canadian study included patients aged ≥66 years treated with spironolactone between April 1992 and March 2010. The outcome of interest was hospital admission with a diagnosis of hyperkalaemia within 14 days of receiving a prescription for co-trimoxazole, norfloxacin, nitrofurantoin, or amoxicillin (trimethoprim monotherapy was not included as it is invariably used in combination with sulfamethoxazole in Canada). A total of 6,903 admissions for hyperkalaemia were identified within the cohort of patients using spironolactone, 306 of which occurred within 14 days of antibiotic use. 10.8% of patients taking spironolactone received at least one prescription for co-trimoxazole. The population attributable fraction was 59.7%, suggesting that approximately 60% of all cases of hyperkalaemia in older patients taking spironolactone and treated with an antibiotic for a urinary tract infection could be avoided if co-trimoxazole was not prescribed. [This would apply to use of trimethoprim alone where this is common practice, as in the UK]. Treatment with nitrofurantoin was associated with a less pronounced increase in the risk of hospital admission for hyperkalaemia. However, nitrofurantoin is contraindicated in patients with a GFR <60mL/min and should be used with caution in elderly patients (increased risk of toxicity).

Action?

Increased awareness of this drug interaction is needed to ensure that the potential consequences are minimised.

Patients taking spironolactone should be prescribed an alternative antibiotic to trimethoprim for urinary tract infections; if this is not possible they should be closely monitored.

This interaction will be particularly important in elderly patients with chronic renal impairment.

In this issue:

CHANGE IN DOVOBET® PORTFOLIO [6,7]

Leo Pharmaceuticals have recently discontinued the 60g size of Dovobet® ointment. The 120g ointment size and both pack sizes of the gel are still available. Patient preference for the gel was given as the reason for the discontinuation. For patients previously receiving the 60g ointment, the default may now be to the 120g ointment size, which could lead to wastage if the patient does not require this quantity.

The cost of Dovobet® products are as follows:

60g	Dovobet® gel	£33.08
120g	Dovobet® gel	£61.43
120g	Dovobet® ointment	£61.43

Action?

Search for Dovobet® 60g ointment issued in the last 6 months

For patients with this item on repeat, consider whether the gel or the larger tube of ointment is the best option

A change to the gel product may be suitable for some patients. However an ointment formulation may continue to be a more appropriate choice for other patients.

OMEGA-3 FATTY ACIDS (OMACOR®) IN PATIENTS WITH TYPE 2 DIABETES WITH CARDIOVASCULAR DISEASE [5]

The December 2012 edition of 'Eyes on Evidence' includes an expert commentary on a randomised controlled trial (ORIGIN) evaluating omega-3 fatty acid supplementation (Omacor®) in patients with type 2 diabetes with evidence of cardiovascular disease.

The study included 12,536 people aged ≥50 years with impaired fasting glucose, impaired glucose tolerance or type 2 diabetes, who had evidence of cardiovascular disease. They were randomised to receive Omacor® 1g or placebo daily. With a median of 6.2 years of follow-up, Omacor® supplementation was not associated with a reduction in the rate of death from cardiovascular causes or any significant effect on the rates of major vascular events, death from any cause, death from arrhythmia or any other predefined study outcome. The authors discuss a number of limitations of this study, including the fact that the dose may have been too low to show an effect, and that participants were taking more cardioprotective therapies than those in the earlier studies, which may have reduced the incidence of cardiovascular events and thus the statistical power of the study.

It is unclear how these findings relate to dietary recommendations to eat more oily fish, as this is associated with an increase in other nutrients and a reduction in consumption of other foods such as red meats. In this study, median weekly dietary intake was 1.5g, which may have been different from earlier studies that showed a benefit of omega-3 supplementation. Other on-going studies (e.g. the UK ASCEND study; results expected 2017) may help to clarify the role of omega-3 fatty acid supplementation in people with diabetes.

Action?

In the meantime, the results of the ORIGIN study support current NICE guidance on type 2 diabetes –omega-3 fish oil preparations should not be prescribed for the primary prevention of cardiovascular disease in this patient group. NICE guidance on the secondary prevention of MI is currently being updated and will consider this issue.

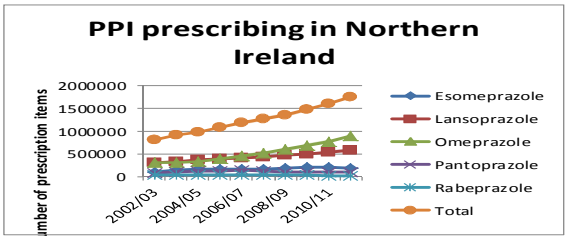
EYES ON EVIDENCE

'Eyes on Evidence' is a free monthly e-bulletin from NHS Evidence, covering major new data as it emerges with an explanation about what it means for current practice. This can be accessed at http://www.evidence.nhs.uk/about-us/eyes-on-evidence.

AN ALTERNATIVE TO ORLISTAT®

HSCB are running a pilot Weight Loss Referral Scheme for primary care. This scheme allows GPs and other professionals working in primary care to refer patients who meet the eligibility criteria for free sessions with a participating commercial weight loss provider. Details can be found at : http://primarycare.hscni.net/pdf/WeightLossReferralLetterReferralForm_final_161012_.pdf. The scheme runs until 31st March 2013.

PPIS: RISKS OF LONG-TERM USE [1-4] [12]



Despite a recent MHRA warning on adverse effects associated with long-term PPI use, the amount of PPIs prescribed continues to rise. PPI use for more than one year and risk of fractures (hip, wrist or spine) and hypomagnesaemia have been flagged by the MHRA as drug safety issues.

Hypomagnesaemia can present as fatigue, tetany, delirium, convulsions, dizziness and ventricular arrhythmias, and can be managed with magnesium replacement and discontinuation of the PPI.

Long-term PPI use has also been linked to increased risk of C. Difficile diarrhoea. Patients need to be informed of these risks and supported in the stepping down and withdrawing of treatment when it is clinically appropriate.

For the majority of patients, PPIs should be prescribed as courses of short-term treatment appropriate for the presenting indication and should not be continually issued on repeat basis without review. This is supported by the NICE dyspepsia guidelines which recommend prescribing PPIs for the shortest possible duration.

Withdrawal of long-term PPIs

The challenge faced by prescribers in withdrawing PPIs is the occurrence of Rebound Acid Hypersecretion (RAHS) and the potential it has for causing further reflux / dyspepsia-type symptoms. RAHS is defined as an increase in gastric acid secretion above pre-treatment levels following discontinuation of antisecretory therapy. There is some evidence to suggest that successful withdrawal of PPI is facilitated by prescribing an alginate during the step-down / step-off period to manage rebound dyspepsia and breakthrough symptoms. By warning patients of the transient worsening of symptoms on stopping treatment followed by a return to normal baseline levels 3-4 weeks later, greater success may be achieved. Patients should be advised about the benefits of discontinuing treatment, including less risk of side-effects and the importance of lifestyle measures in aiding withdrawal of treatment. The HSCB has a resource tool which can help practices identify patients that are suitable for step-down of PPIs and it can be found at: http://primarycare.hscni.net/pdf/BCBV_PPI_step-down_SOP_final_Aug_2010.pdf

Action?

- When appropriate, prescribe PPIs as short courses of treatment appropriate to the indication
- Advise patients regarding long-term side-effects of PPIs
- Review the indication and appropriateness of PPIs in long-term users periodically
- Consider prescribing alginate cover to help manage rebound symptoms when stepping down or stepping-off
- Warn patients of a short-term relapse on reducing/stopping PPIs
- Consider measuring magnesium levels before starting PPI treatment and repeat measurements periodically during prolonged treatment, especially in those also taking digoxin or drugs that may cause hypomagnesaemia (e.g. diuretics).

DRESSINGS – GUIDANCE FOR OBTAINING NON-FORMULARY DRESSINGS IN EXCEPTIONAL CIRCUMSTANCES [12]

In 2007 the DHSSPS introduced a Regional Formulary for wound management products in Northern Ireland. This Formulary was reviewed and a new wound care formulary commenced on the 1st February 2011. Over recent months the HSCB has received a number of enquiries from prescribers, in relation to the circumstances in which the alternative / exceptions protocol might be triggered.

Action?

A product listed on the alternative/ exception protocol can be considered, if:

1. The normal pathway of good wound care has been adhered to; and a formulary dressing product has been in use for a minimum of two weeks and the wound still fails to progress.
2. Patient experiences (or has a history of) an adverse reaction specifically to a formulary dressing product, e.g. an allergic reaction.
3. If the patient requires the application of an alternative product not available on the Wound Care Formulary due to their clinical status/ special skin or wound care needs.

Nominated representatives can request an alternative/ exception protocol dressing provided the following has been taken into account; holistic assessment; intrinsic and extrinsic factors that may impede healing.

For details of nominated representatives e.g. TVNs/podiatrists who are authorised to request alternative/ exception protocol dressings, please contact your local TVN / podiatry team or:

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Alternative/ Exception Protocol Dressings will be supplied through nominated HSC Trust Pharmacy Department (refer to local arrangements).
Forms for Requests for Non-Formulary Wound Products may be accessed at the following link
http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/Wound%20Care/index.html#P-1_0

The Northern Ireland Wound Care Formulary (second edition, April 2011) is available to view electronically on the following website:
www.hscboard.hscni.net/medicinesmanagement/index.html

REPEAT DISPENSING – REMINDER ABOUT PINK FORMS [11]

The Repeat Dispensing Communication Pro-forma is for use by both GPs and community pharmacists to facilitate the transfer of information on patient participating in the repeat dispensing scheme. Details on how to complete a Pro-Forma can be found on the HSCB website: http:www.hscbusiness.hscni.net/pdf/Dispensing_Communication_Pro_forma.pdf.

Please note that latest editions of proforma pads contain white and yellow copies only. There had originally been a pink copy that was sent to the Repeat Dispensing Facilitator in LinenHall Street, Belfast.

Action?

There is no longer a requirement to forward pink copies to HSCB. Any pink copies from older pro-forma issues may simply be destroyed.
White copy – forward the top white copy to the patient's GP/Pharmacy
Yellow copy – retain the 2nd yellow copy file in the patient's notes

MIDAZOLAM BUCCAL SOLUTIONS [8]

Practices are reminded about the need to brand prescribe midazolam buccal solutions. The two most commonly used products are Buccolam® 5mg/mL oral liquid and Epistatus® 10mg/mL oral liquid (unlicensed).
Buccolam has a licence for paediatric use and is available in a range of prefilled oral syringes. Epistatus® is available from 'specials' manufacturers in a multi-dose bottle and as prefilled oral syringes. Another generic buccal midazolam 10mg/mL product (unlicensed) is available from 'specials' manufacturer UL Medicines.
It should be noted that Buccolam® (5mg/mL) is half the strength of some other unlicensed preparations. There is therefore the potential for errors to occur.

Action?

- Buccal midazolam should be prescribed by brand name. If it is not prescribed by brand name, pharmacists should check the intended product with prescribers.
- Doses of buccal midazolam should be prescribed in'mg'.
- Refer to HSCB Medicines Safety Alert for further information: http://www.hscboard.hscni.net/medicinesmanagement/Medicines%20Safety%20Alerts/010%20No10%20Risks%20with%20Buccal%20Midazolam%20-%20June%202012%20-%20PDF%2062KB.pdf

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This newsletter has been produced for GPs and Pharmacists by the Regional Pharmacy and Medicines Management Team. If you have any queries or require further information on the contents of this newsletter, please contact one of the Medicines Management Pharmacists in your local HSCB office.

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